5 Glossary

This section defines common abbreviations and terms used in this manual.

For further information or questions about terms used in this manual, please call an EDS provider service representative at: **(208) 383-4310** in the Boise calling area or **(800) 685-3757** (toll free)

Provider representatives are available Monday through Friday 8:00 a.m. – 6:00 p.m. MT (excluding state holidays).

A.

Accommodation: An institutional facility room charge (private, semiprivate, ward, etc.) or revenue codes 100-219.

ACCESS Unit: Access to Care Coordination, Evaluation, Services, and Supports Unit, that manages services for adults with developmental disabilities.

Adjudication: Resolution of a pended claim to determine whether a claim is to be paid or denied.

Adjustment Reason Codes: A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it.

Adjustments: Changes made to correct an error in billing or processing of a paid claim. These conditions are detected by claims personnel, by providers or by a Department of Health and Welfare agency. Possible errors include:

- Overpayment.
- Underpayment.
- Payment to the Wrong Provider.

Admission: Actual entry and continuous stay of the participant as an inpatient to a hospital or nursing home.

AIM: Advanced Information Management system.

Allowed Amount: That part of the reported charge that qualified as a covered benefit, eligible for payment under the Idaho Medicaid Program.

ALS: Advanced life support.

Ancillary Services: Services available to a participant other than room and board. For example: pharmacy, x-ray, lab, and central supplies.

Appeal: An action taken by a provider who disagrees with the adjudicated result of a claim.

Attending Physician: The physician rendering the major portion of care, or having primary responsibility for care of the major condition or diagnosis.

AWP: Average wholesale price.

B.

Benefits: Services available under the Idaho Medicaid Program.

Billed Amount: The amount billed to Medicaid for a rendered service.

Billing Provider: The individual provider, institution, or group practice submitting claims for payment.

BLS: Basic life support.

C.

Claim: A request for payment for services rendered on a standardized form (CMS-1500 (08/05) claim form, UB-04 claim form, ADA Dental claim form, or Pharmacy claim form) or electronic record.

Claims Processing Contractor: A private business that has contracted with DHW to process Medicaid claims.

Clearinghouse: A facility that receives electronic insurance claims from providers and routes them to the appropriate insurance carriers for processing.

CMS: Centers for Medicare & Medicaid Services, Federal entity that governs Medicare and Medicaid programs.

CMS-1500 (08/05) Claim Form: Medical claim form used for billing physician and other services to insurance companies.

Coinsurance: The portion of charges the participant is responsible for under Medicare or a private insurance. This may be covered by other insurance such as Medi-Pak, AARP, or Medicaid.

Coordinated Care: Health care program where an assigned provider agrees to become the primary care case manager and coordinates all of the participant's care (Healthy Connections).

Cosmetic Surgery: Any surgical procedure directed at improving physical appearance but not medically necessary.

Covered Services: Service that is within the scope of the Idaho Medicaid Program.

CPT: Current procedural terminology. An American Medical Association approved listing of medical terms and identifying codes for reporting medical services and procedures performed by providers.

Crossover Claims: Claims for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable to pay for services rendered to a participant entitled to benefits under both programs.

D.

DDA: Developmental disabilities agency.

DESI: Drug efficacy study implementation. DESI drugs lack substantial evidence of effectiveness for all labeled indication. This also applies to identical, similar, and related drugs. Medicaid will not reimburse providers for these drugs.

DHW: Department of Health and Welfare.

Diagnosis: The identity of a condition, cause, or disease.

DOS (Date of Service): Date or span of days when a participant received services.

Duplicate Claim: A claim that has been submitted or paid previously.

DUR: Drug utilization review.

DME (Durable Medical Equipment): Equipment other than prosthetics or orthotics which can withstand repeated use by one or more individuals, is customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, or is appropriate for use in the home. Coverage is limited to the least costly means that will reasonably and effectively meet the minimum requirements of the individual’s medical needs.

E.

EAC: Estimated acquisition cost.

ECS: Electronic Claim Submission

EDI: Electronic data interchange.

EDS: Fiscal intermediary agent for the Idaho Medicaid Program.

EDS Billing Software: Provider Electronic Solutions (PES).

Eligible:

1. To be qualified for Medicaid benefits;
2. One who is qualified for benefits.

EOB: Explanation of benefits. A code number describing the action taken on the claim and reason for payment/nonpayment of services.

EOB Message: Explanation of Benefits message that describes the narrative reason for payment, denial, or return of a claim.

EOMB: Explanation of Medicare Benefits. A code number describing the action taken on the claim and the reason for payment/nonpayment of services by Medicare.

EOMB Message: Explanation of Medicare benefits message describes the narrative reason for payment, denial, or return of a claim by Medicare.

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment. A Federally mandated, preventive health care program for eligible individuals under the age of 21.

F.

Fiscal Agent: An organization authorized by DHW in Idaho to manage and operate the Medicaid Management Information System (MMIS).

Fiscal Year: The 12 month period between settlements of financial accounts.

FQHC: Federally Qualified Health Center.

Follow-Up Action Code: Indicates what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

FUL: Federal upper limit.

G.

Group Practice: A medical practice where several practitioners render and bill for services under a single provider number.

H.

HCPCS: Healthcare common procedure coding system.

Healthy Connections: The trademarked title for the Idaho Medicaid Coordinated Care Management Program.

HIC Number: Health insurance claim number assigned to Medicare participants.

HIPAA: Health Insurance Portability and Accountability Act of 1996.

HMO: Health maintenance organization.

HMS: Contractor for third party insurance verification.

I.

ICD-9-CM: International Classification of Diseases 9th Edition-Clinical Modification. A listing used by providers in coding diagnoses on claims.

ICF/MR: Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded.

ICN: Internal control number. The unique number assigned to each Medicaid claim that allows tracking in the system.

ICSP: Individual community support plan.

IDAPA: Idaho Administrative Procedures Act.

IEP: Individual education plan.

Inpatient: A participant admitted to a hospital or skilled nursing facility who occupies a bed and receives inpatient services.

Institutional Care: Care in an authorized private, nonprofit, public, or state institution or facility. Such facilities include schools for the deaf, blind, and institutions for the handicapped.

Intensive Care: Isolated and constant observation of critically ill or injured participants.

Interactive Electronic: The on-line, real time submission of pharmacy claims to EDS.

Interim Billing: A claim that is divided and submitted in two or more parts, usually an inpatient claim.

ISP: Individual service plan.

J.

Julian Date: Chronological date of the year, 001 through 365 or 366, preceded by a four-digit year designation. Example: 2005321 is the 321st day of 2005.

L.

Legend Drug: A drug that cannot be dispensed without a prescription.

LOS (Length of Stay): Period of time that a participant is an inpatient in a nursing facility or hospital.

Lien: A charge upon real or personal property for the satisfaction of some debt or duty ordinarily arising by operation of the law.

Line Item: A single line on a claim form or ECS record reflecting a service provided to a participant. A claim may be made up of one or more line items for the same participant.

Lock-In: A program that restricts a participant to receive primary care directly from one physician (or a referral from that physician) and receive pharmacy services from a single pharmacy.

LTC (Long-Term Care Facility): A nursing facility that provides 24 hour nursing care.

M.

MAVIS (Medicaid Automated Voice Information Service): The automated voice recognition system used by providers to find information on participants, claims, and enrollment status.

MAID (Medical Assistance Identification) Card: A participant identification card used by participants to show their eligibility for Medicaid benefits.

Medicaid Basic Plan: For low-income children and adults with eligible dependent children. This plan provides complete health, prevention and wellness services for children and adults who don't have disabilities or other special health needs.

Medicaid Enhanced Plan: Includes all services of Medicaid Basic Plan benefits, plus additional services to cover the needs of participants with disabilities or special health concerns. The services in this plan include the full range of services covered by the Idaho Medicaid Program

MID (Medicaid Identification) Number: Medicaid's participant identification number. A unique 7-digit number that identifies a particular participant.

Medical Necessity: A service is medically necessary if:

- It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction.
- There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.
- Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality, those records shall be made available to DHW upon request.

Medicare Savings Program (formerly Buy-In): A process whereby DHW enters into an agreement with the Bureau of Health Insurance, Social Security Administration, to obtain supplementary medical insurance benefits (Medicare, Part A and Part B) for eligible participants. DHW pays the monthly premium on behalf of the participants.

Mental Health Authority: DHW State mental health services as administered through its regional mental health programs.

MMIS: Medicaid Management Information System. The automated system utilized to process Medicaid claims and support program administration.

MRN: Medicare remittance notice. Report that explains how and why a claim was processed as it was.

Multi-Source Drug Upper Limit Waiver: That action taken when a prescriber has specifically requested a particular brand of multi-source drug, having a cost per dose, in excess of the established upper limit of payment. The prescriber request must be handwritten and state, Brand Medically Necessary, or similar wording, and be signed or initialed by the prescriber. The notation must be on the prescription itself or in the form of a separate document attached to the prescription.

N.

NDC: National drug code.

NF: Nursing facility.

Non-Covered Services: Services not covered under the Idaho Medicaid Program. This includes any services that are not medically necessary or provided for the personal convenience of the participant.

O.

OI: Other insurance.

OTC: Over-the-counter.

Outpatient: A participant receiving medical services but not admitted to a hospital.

P.

Patient: A person under treatment of care, as by a physician or surgeon, or in a hospital. Referred to as a participant in Medicaid when the person meets the Medicaid eligibility requirements and is eligible for medical services.

Participant: A person who meets the Medicaid eligibility requirements and is eligible for medical services.

Participant Contribution: Money deducted from a personal care provider's payment that the participant pays to the provider as a contribution toward their care.

Payment-in-Full: Under the Medicaid program, payments made to providers that are determined to be the reasonable charges for the services provided constitute payment in full.

Peer: A person or committee in the same profession as the provider.

Peer Review: An activity performed by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally accepted standards. See QIO.

Pended Claim: A claim that has been processed at least once and has issues that must be reviewed and resolved before a claim can be paid.

PES (Provider Electronic Solutions): The electronic claims submission and eligibility verification software, offered by EDS free of charge to providers. The software can be used for eligibility and claims submission.

Point-of-Sale (POS): An automated processing capability to submit pharmacy claims interactively and receive an automated response.

Place-of-Service (POS): The physical location where a service is rendered.

Point-of-Service (POS): An automated processing capability using a device and magnetic card or key entry to submit a request for information and receive an automated response. HIPAA compliant devices are required.

Post-payment Utilization Review: The review of services and practice patterns after reimbursement.

Prescription Drugs: Drugs (also called legend drugs) which, in accordance with Federal and State statutes, may not be obtained unless prescribed by a physician.

Presumptive Eligibility (PE): A unique eligibility status as defined in, *Section 1.4.3 Presumptive Eligibility (PE)*, of this handbook.

Prevailing Charge: The seventy-fifth percentile of customary charges for a particular procedure or service within a specific geographic location during the base year.

PCCM (Primary Care Case Management): A health care program where an assigned provider agrees to become the primary care case manager and oversees all of the participant's care.

PCP (Primary Care Physician): The provider responsible for the treatment and supervision of the participant's health care needs.

PA (Prior Authorization): The approval that must be given by DHW or its contractors for requested services for a specified participant to a provider before the requested services may be performed and before payment is made. A Notice of Decision is issued when a PA is either approved or denied.

Procedure Code: A code used to identify a medical service and procedures performed by a provider.

Professional Component: The portion of a diagnostic service that relates to the professional services rendered.

Provider: A person, organization, or institution authorized to provide health or medical care services under the Idaho Medicaid Program.

Provider Agreement: Written agreement between a provider of medical services and DHW. A contract must be signed by all providers of service participating in the Idaho Medicaid Program.

Provider Electronic Solutions (PES): The electronic claims submission and eligibility verification software offered by EDS free of charge to providers. The software can be used for eligibility and claims submission.

Provider Number: A unique, 9-character code assigned to each Medicaid provider of service in Idaho for identification purposes.

PW: Pregnant Women Program.

Q.

QIO (Quality Improvement Organization - Qualis Health).

QMB (Qualified Medicare Beneficiary): Certain individuals qualify for the Qualified Medicare Beneficiary (QMB) Program and are eligible to have their coinsurance and deductible paid by Medicaid.

R.

Recoupment: A sum of money to be taken back from a provider to satisfy a debt owed to the Idaho Medicaid Program.

Referring Provider: The identification of the provider who referred the participant to another physician or practitioner for further medical services.

Reimbursement: The amount of money remitted to a provider.

Reject Reason Codes: Indicates the reason why the transaction was unable to process successfully. There are two types of reject reason codes: eligibility and pharmacy.

Reject Reason Codes for Eligibility Response Transactions: Assigned by the MMIS to identify the reason for the eligibility rejection.

Reject Reason Codes for Retail Pharmacy Claims: Received from the primary payer. They are the approved codes that explain to Medicaid why the primary payer did not cover the claim. The codes listed allow Medicaid to process claims without pending for third party review.

Rejected Claim: A claim for which processing is refused because it does not meet the minimum submission guidelines of the Idaho Medicaid Program or is not in a HIPAA compliant format.

RA (Remittance Advice): An RA is produced weekly to show all claim activity for a particular provider. Also called a remittance and status report, this notice to providers advises the status of claims received. Paid, denied, in-process, and adjusted claims may be reported on RAs.

REOMB: Recipient Explanation of Medicaid Benefits form sent monthly to a selected sample of Medicaid participants to verify they received services that have been billed and paid.

Retroactive Medicaid Eligibility: Medicaid eligibility that was determined to cover a time prior to the date the participant originally received eligibility.

RMS: Regional Medicaid Services.

S.

Sanction: Any disciplinary action taken against a provider.

Screening: The process used to prevent or detect the onset of catastrophic illness, disease, or developmental orders.

Specialty: The providers specialized area of practice.

S/UR: Surveillance and Utilization Review.

Suspended Claim: A claim that is pended during system processing for suspected error conditions. These conditions must be reviewed and resolved before processing can be completed.

T.

TBI: Traumatic brain injury.

Technical Component: The portion of a diagnostic service rendered that relates to equipment usage and supplies.

TPR (Third Party Recovery): This process identifies a person or an organization (other than the participant or Idaho Medicaid) responsible for all or some portion of the costs for health or medical services incurred by a Medicaid participant (a health insurance company, a casualty insurance company, or another person in the case of an accident, etc.).

TPR Reject Reason Code: This code indicates the action taken by the primary insurance when processing the claim.

U.

UB-04 claim form: To meet HIPAA mandated billing requirements, the UB-92 claim form was updated to UB-04 claim form with added fields to support the required data billing elements.

Usual and Customary Charge: Charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

Unit Dose Dispensing: For Title XIX payment purposes, the provision of individually sealed and labeled unit-of-use medications that ensures no more than a 24 hour supply in any nursing home participant's drug tray at any given time including weekends. Delivery of drug cabinets containing each day's medication is to be at a minimum of a five day per week basis.

V.

Void: A transaction that has the effect of deleting a prior claim payment.

Void and Replacement: The electronic equivalent of a claim adjustment.

W.

Workers' Compensation: A type of third party recovery for medical services rendered as the result of an on-the-job accident or injury to a participant for which their employer's insurance company may be obligated under the Worker's Compensation Act.